Dutch euthanasia law always meant for groups that now receive euthanasia

The euthanasia law options have not been expanded

There seems to exist an idea that the boundaries of the Dutch euthanasia law are slowly being extended. The situations which are seen as new, however, always fell within the limits of the law, as is shown here by Laura De Vito.[1]

Introduction

The Dutch *Law on the termination of life on request and assisted suicide*[2] is the oldest euthanasia law (that still exists[3]) in the world. The Dutch are honoured, praised and envied for it, but also criticised. One of the criticism is that this law will finally end up in a 'slippery slope'. With this criticism is meant that the scope of the law will be stretched in time, which results in a practice that was never foreseen by the legislator. This criticism does not only arise in foreign countries, but also in the Netherlands itself. For example, this year the Dutch physician Bert Keizer wrote in a magazine for physicians: "(…) I briefly mentioned what happened to euthanasia candidates: first the terminally ill, then the chronically ill, then psychiatric patients, then people with starting dementia, then with advanced dementia, then stacking old-age complaints, then completed life and as an insane outgrowth the observation of the *Cooperation Last Will* (CLW) that anyone above the age of 18 may just die." [4] With this statement, the suggestion may be that the law was only made for terminally ill patients, and that the practice has grown out of this scope. In 2017, another physician, psychiatrist Boudewijn Chabot, suggested specifically that the practice of euthanasia in case of advanced dementia does not fall within the scope of the law: "The legislator had never even thought of euthanasia in case of developed dementia."[5]

It is true that more and more people receive euthanasia, and it is also true that the group of people in difficult situations, like in psychiatry, with dementia and with old-age complaints but without a severe disease, increases strongly the last years. A lot of people think, fed by 'experts' like the already mentioned physicians, that the Dutch law was only meant for people who suffer from a terminal illness, who have to bear incredible pain all day, and who are going to die soon anyway. From that point of view, you can't blame them to think the Dutch euthanasia practice has ended up in a so called 'slippery slope'. However, the legislator thought and spoke already about the other, difficult groups, by at the time the law was made. Reading the extensive considerations, the conclusion is that the space for these difficult groups has been there from the beginning.

Lack of terminal illness / dying phase

The well-known Postma judgment[6] is often seen as the basis for the current euthanasia law. In this case, five criteria were suggested by the judge, four of them are now in the law as due care criteria. However, the fifth criterion did not come into the law and was not taken over by the court at that time. This criterion concerned the requirement of the so-called dying phase. This criterion has not

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[1] Laura De Vito is legal advisor of the Dutch Association for a Voluntary End of Life (NVVE). This article is an editing of an article that will appear (in Dutch) in September 2018 in a Dutch magazine for physicians: Medisch Contact.

[2] https://www.worldrtd.net/news/dutch-law-termination-life-request-and-assisted-suicide-complete-text

[3] The state of Northern-Australia had the first euthanasia law in 1997, but this was recalled by the federal government.

[4] Medisch Contact, 20/2018: 13

[5] Trouw, 20-05-2017

[6] Postma, Court of First Instance Leeuwarden, 21-02-1973, ECLI:NL:RBLEE:1973:AB5464:
'D. de stervensperiode van de patiënt naar medisch oordeel is ingegaan of zich heeft aangekondigd.'

been adopted by the court because the judges were of the opinion that many people who suffer unbearably might continue to live for years. The judges found it incorrect if this group for that reason (which makes the suffering only worse) would be denied the opportunity to end their suffering by means of euthanasia: “A person does not have to be terminally ill to avoid unbearable and hopeless suffering.”

Ten years later, in another case, the Supreme Court confirmed this view. In the so-called Chabot-judgment the question was whether assisted suicide could be justified now that the deceased person was not in a dying phase. The judges ruled that the continuation of the dying phase as criterion would be too restrictive: “The specific nature of a state of emergency which may lead to the judge's judgment that the fact was justified, precludes a general limitation as to the existence of the dying phase.” [7]

In the end the legislator as well adopted this view. When the law was drafted the following argumentation was used: '(…) the starting point for the prosecution policy can no longer - partly - be that there must have been a dying phase. The position of the previous cabinet that a physician must choose for life-preservation in a non-terminal phase of a disease process, in which improvement cannot be expected in the short term, cannot be maintained in the light of the judgment of the Supreme Court. '[8]

Dementia

Situations of beginning and advanced dementia have been extensively discussed in the parliamentary debates, held prior to and during the creation of the law.

Regarding incipient dementia, the legislator finally decided that euthanasia could be possible, based on suffering from the awareness of and fear for further detachment. The Schoonheim-judgment has been of importance for this development since it introduced in 1984 the concept of 'further detachment of the person and the prospect of not dying in a dignified way'.[9] In 2000, the then Minister of Healthcare Borst said the following: “(…) discussed is suffering from the prospect of dementia. I certainly think this is possible. There are several testimonies from people who have very well put that into words. They noticed that Alzheimer's disease has struck them while they are still clear enough to understand what is going to happen, how they will slowly decline and how their personality and their identity will be lost. They suffer from that prospect. That suffering can be unbearable and hopeless."[10]

When it comes to advanced dementia, the then minister of Justice Korthals considered euthanasia possible in this situation: "If an incapacitated patient, for example a deeply comatose or a deeply demented patient, has formulated an advanced directive, the physician can grant the request for the termination of life”.[11] Member of parliament Swildens said it even stronger: “It was precisely for the condition of dementia that the advanced directive was meant. Such a detachment and feeling of unworthiness one wants to save itself. My party is of the opinion that people should be surrounded with great love and care in their life-time, also in situations of confusion - such as advanced dementia. This does not detract from the fact that there are people who judge the unhappiness that they have in mind so unworthily that they do not want to experience it.”[12]

The suffering is difficult to establish but can still be there, and consist of additional symptoms. Minister Borst said: “If you continue in the process of dementia, the dementia does not in itself

[7] Chabot, Supreme Court (Penal section), 21-06-1994, ECLI:NL:HR:1994:AD2122
[8] Parliamentary document 23877/1, page 4. Relevant because the explanatory memorandum (parliamentary document 26691/3, page 10) refers to this document when it comes to unbearable suffering.
[9] Schoonheim, Supreme Court (Penal section), 27-11-1984 (NJ 1985, 106), ECLI:NL:HR:1984:AC8615
[10] Parliamentary document 26691/22, Report of a legislative consultation, page 69
[11] Parliamentary document 26691/22, page 62
[12] Parliamentary document 26691/22, page 8

automatically become intolerable and hopelessness for the completely demented patient. However, it may happen that a totally demented patient suffers. This may have to do with additional other complaints." What these other complaints can be, is well described in two guidelines that the Dutch government published in 2015.[13] For example think of anxiety, distress and pain.

Two years after the implementation of the law, in 2004, a man who suffered from dementia received euthanasia:

Committee report 2004, page 15-16, casus 3
A 65-year-old patient suffered from Alzheimer's disease for three years. The depressive complaints that arose in connection with this became medicamentous with success treated. In addition, the patient received day treatment in a nursing home. Patient he suffered unbearably from the fact that he could no longer function independent in any way. He also suffered greatly under the insight into his future as a demented patient. From the beginning of his illness, the patient has made it clear to the doctor that he is did not want to go through the entire disease process. In the course of the year before in the execution of the termination of life he has the doctor repeatedly for help in suicide.

The doctor consulted a consultant. According to the consultant, the patient was unbearable under the dependence of others, the awareness of decay and decorum loss, the loss of autonomy and self-esteem and the knowledge that his situation alone but would worsen. Nevertheless, the consultant found the suffering of the patient inadvisable. Moreover, would be realize his shortcomings only decrease in the further course of his disease. As a result, the unbearabillity of his suffering would over time only become less. According to the consultant, there was indeed one for a long time consistently voiced euthanasia request, but was the ability to act of the patient disputable, since he could not argue during the consultation to follow. The consultant concluded that the due care requirements had not been met. After the assessment by the consultant, the doctor consulted three more experts: a psychologist, a nursing home doctor and a geronto psychiatrist. From the research that each of these experts has set up separately became clear that there was no depression in patients, that patient would like to be in control wanted to keep his life alive and that he was aware that it was progressing of the disease would deprive him of this control. The experts consulted each came to the conclusion that patient was able to make a voluntary and well-considered request for termination of life to express and that he was aware of the consequences of his choice. Following the conclusion of these experts, the doctor decided to honour the patient's request. The patient died as a result of assisted suicide.

In its judgment, the Committee considered that the consultant may have question marks put on the will of the patient but that the later consulted experts each came to the conclusion that patient is indeed willing and able to determine and substantiate his will. According to the committee, the doctor had met the requirement of the consultation. In the opinion of the committee, the doctor had to face the contradictory opinions of the consultant and the experts subsequently consulted, on the basis of his own insight rightly attributed more weight to the judgment of the later consulted experts. According to the committee, the doctor had this on the basis of this may decide to resort to assisted suicide. The committee ruled that the doctor had acted in accordance with the due care requirements.

[13] https://www.rijksoverheid.nl/documenten/kamerstukken/2015/12/17/kamerbrief-over-handreikingen-schriftelijke-wilsverklaring-euthanasie

Psychiatric suffering

The already mentioned Chabot-case is in the first place famous and important because of its considerations regarding psychiatric suffering. In this case the Appellate Court and later the Supreme Court came to the conclusion that also psychiatric suffering can be defined as suffering in accordance within the scope of the law. The judges ruled that assisted suicide was not excluded in advance for people who suffer without somatic cause: "This suffering must be abstracted from the cause in that respect that the cause of suffering does not detract from the extent to which it suffers is experienced."[14]

The legislator adopted this vision: "Crucial is the consideration of the Supreme Court [in the Chabot case] that an appeal to an emergency situation is not simply excluded on the sole ground that the unbearable and hopeless suffering of a patient does not have a somatic cause (...). The conclusion of these considerations should be that the Supreme Court leaves open the possibility that a physician invokes a state of emergency (and is therefore not punishable) if a patient (physically and / or mentally) is suffering unbearably and hopelessly, and asks urgently and repetitively for the application of euthanasia."[15]

In 2000 this disconnection between the cause of the suffering, and the suffering itself, was criticised by some parliament members. The direct cause of this criticism was the coming into court of the famous Brongersma-case. In this case a person was given assistance with his suicide, because 'the menu of life did not have much to offer' to him, what later would be called: a completed life. Many members of parliament thought this was a bridge too far. A member of the Socialist Party concluded this was a result of the Chabot-vision: "One of those norms is the unbearable, hopeless suffering. This standard has been stretched by the Chabot judgment in such a way that it can be said that we have since ended up on a slippery slope. The norm has been stretched, because there was not yet a dying phase, the suffering did not involve somatic suffering and the assessment was separated from the cause of suffering. The correspondence between physical and spiritual suffering is that the pain always manifests itself psychically and that therefore the cause and the suffering can be separated from each other. The difference is that in mental suffering the seriousness of the hopelessness is more difficult to establish objectively than in the case of physical suffering. My party considers that an important difference. If psychological suffering falls under the criterion, and according to jurisprudence, it now tends to autonomy. I then refer to autonomy in the sense of: I do not want anymore, and because I no longer want it, it is psychologically unbearable. Where is the border?"[16]

The Minister of Justice Korthals answered to this member briefly, and only said that 'completed life' as such would not be enough: "The mere prospect of suffering, regardless of whether this will result from pain, detachment or fear of an unworthy death, cannot be regarded as hopeless and unbearable in the light of the above. This also applies to a very elderly person who feels his life is at the end. This refers to people who are often of old age and who, moreover, do not suffer from an untreatable illness or disorder that is unmanageable and, with serious suffering, have having established for themselves that the value of life has decreased to such an extent that they want to rather choose death than living on. We do not go so far as to think that anyone who no longer has a will to live must have the regulated possibility to end life." [17]

Later on, he formulated an other answer: "Although the cause of suffering as such is not decisive for the question whether there is suffering, the situation of the patient must be able to be characterized as a suffering through *medical ethical* insight. There must therefore be a *medical dimension* to the

[14] Chabot, Supreme Court (Penal section), 21-06-1994, ECLI:NL:HR:1994:AD2122
[15] Parliamentary document 23877/1, page 4. Relevant because the explanatory memorandum (parliamentary document 26691/3, page 10) refers to this document when it comes to unbearable suffering.
[16] Parliamentary document 26691/22, Report of a legislative consultation, page 38-40
[17] Parliamentary document 26691/22, Report of a legislative consultation, page 59

suffering, which may perhaps be regarded as a disease."[18] By adding another criterion: the existence of a medical classification, he solved the problem that was caused by the Chabot-judgment. He moved away from the principled idea that the cause of the suffering is not relevant, what would led to ethical problems, as the parliament member has seen correctly, but he did not move away from the outcome of the Chabot-case that also psychiatric disorders could lead to euthanasia. In 2002 the Supreme Court as well ruled in this Brongersma-case[19] that the cause of suffering must have a medical dimension; otherwise it would be too far removed from the medical practice. Therefore, cases in which psychiatric disorders play a role do fall within the scope of the law (psychiatry is part of the medical system), but cases in which only psychological problems exist, do not.

Already in 2003 a euthanasia request by a patient with psychiatric disorders was honoured and approved by the review committee:

Committee report 2003, page 17, Casus 5
The report concerned termination of life on request by a patient with a clear psychiatric mood and borderline personality disorder confirmed by multiple consultants , leaving no doubt about the medical context. In between the periods of depression and panic attacks, the patient functioned marginally. In those periods he expressed his desire to die powerfully and determined. From the moment that the patient came to the doctor's practice, he spoke with the doctor about the possibility of life termination. The patient had a written declaration of will prepared and signed, addressed to the doctor, in which he comprehensively reported his situation and articulated his request for termination of life. The doctor, in all the years that patient was in his practice, had grown to accept and respect the patient's wish. He was finally convinced of the unbearability of the suffering of his patient. Consultation with his friends' close friends supported him in his conviction. He named it one a personal quest he had made with his patient, eventually culminating in offering help with the very intrusive desire of his patient to be allowed to die. The consultant - a psychiatrist - visited the patient several times. He came to the conclusion that the patient was competent. He had a good sense of understanding in his illness. The intolerance of suffering was for the consultant - in view of the severity of the psychiatric condition, the permanent disability and the expected deterioration - palpable. The consultant was of the opinion that the due care requirements were met. The committee came to the conclusion in this case that the doctor acted according to the due care requirements.

Completed life

When the discussion about the law was finally finished, and parliament was ready for voting on it, the already mentioned Brongersma-case came to court. In that case, as explained, the question arose whether a person who does not suffer from a particular disease, but who considers his life as 'complete' could be honoured in a request for euthanasia or assisted suicide to a physician. When some parties in parliament heard of this case, they made clear that if these 'completed life' situations would fall within the scope of the new law, they would recall their support for the law. For that reason the ministers explicitly defined that these situations would not fall within the scope of the law. As reason they brought up the distance between physicians and non-medical issues: "Suffering that arises from other than a medical context should not be judged by a doctor. Such a suffering goes beyond the profession of the physician. Situations in which there is such suffering are also not covered by the present bill."[20] This all makes clear that 'completed life' as reason to ask for euthanasia, has from the start been excluded from the scope of the law. And still today it does not function as legal basis for euthanasia.

[18] Parliamentary document 26691/173b, Response to earlier questions, page 34
[19] Brongersma, Supreme Court (Penal section), 24-12-2002 (NJ 2003/167), ECLI:NL:HR:2002:AE8772
[20] Parliamentary document 26691/173b, Response to earlier questions, page 32

However, the term ‘completed life’ refers in the first place to the subjective perception of the applicant. It does not mean that a person cannot have, objectively, medical problems besides the feeling of a completed life. And then it is important what the ministers also said: “It is the judge who has to assess the due diligence requirements on the basis of all available facts. This means that the judge must assess whether life fatigue is accompanied by a suffering in the medical sense.”[21] This combination of suffering in medical sense will be discussed in the next paragraph.

Old-age complaints

A combination of various old-age complaints is the only concept that was not yet used when the law came into force. This formulation was created in the ‘jurisprudence’ of the review committees and was explicitly mentioned by the KNMG (RDMA, Royal Dutch Medical Association) in 2011 in its position paper on the role of the physician in a self-chosen end of life.[22] Whether this was a major shift from the situation before can be disputed. In practice this may be the case, as many people with these complaints feel they have a ‘completed life’, and since this concept as ground as such was explicitly ruled out from the scope of the law, people thought that a completed life was a contra-indication for euthanasia. However, this was never the case: the only thing that counts is the existence of a medical classification. If this is available, it is not relevant how the person experiences his or her suffering: as suffering from pain or as suffering from the feeling that his or her life is ‘completed’. Theoretically the introduction of the ‘old-age complains’ concept must then be seen more as a clarification of the law than a change of it. After all, the criterion from 2001 is 'medical basis' or 'medical dimension' and a stacking of old age complaints is just one example of this.

That this is the case also turns out from the fact that already in the first year that the law was in force, in 2002, a person with old-age complaints received euthanasia:

Committee report 2002, pages 24-25, Casus 9

A 82-year-old patient suffered from an accumulation of age-related illnesses. Since 1980 he had glaucoma for which he underwent multiple operations. His eyesight deteriorated in the course of time. He also had, since the 80-ies diabetes and hypertension. In 1997, patient received a multi- brain infarction after which there was moderate to severe memory loss. About a month before his death he suffered a stroke after which for some days he experienced paralysis symptoms. After this stroke, the patient had become completely and permanently blind . The doctor was asked by the committee to provide further (written) information and was subsequently also heard by the committee. The doctor emphasized that his patient, in addition to his blindness, suffered from various serious conditions, including serious ones as vascular diseases in several places in the body (brain, heart and legs, accompanied by ulcers) and recurrent cerebral infarctions, causing up to three times paralysis symptoms and memory disorders. Another handicap was that he walked very difficultly due to a numb feeling in the feet due to the diabetes and balance disorders. Because of blindness and memory loss and also the loss of his wife and son, the patient experienced his life as meaningless and unbearable. He was well aware of that a new stroke could occur at any time, leading to further disability. The patient's fear of this was, according to the doctor, very real. After he had suffered for years under his visual impairment, he did not want to accept complete blindness. Even more suffering was unbearable to him. The doctor stated that there were no more possibilities for improvement of the diseases. The doctor had offered patient antidepressants and help from a psychologist, but this was rejected by the patient, because this would not bring an improvement in his physical handicaps. The doctor stated both in writing and orally that in the course of time he had become convinced that the patient was suffering hopelessly and unbearably. During the last week of his life, the patient refused to eat and drink, which caused the diabetes to be disrupted. The doctor expected that patient, in view of the dehydration and disordered diabetes, would die within one week. The consultant concluded that the euthanasia request met the statutory due care criteria. Considering everything and considering the explanation from the doctor, the committee was of the opinion that, according to prevailing medical insight, the suffering was hopeless and unbearable . It was the commissions opinion that the doctor had acted in accordance with the due care requirements.

Conclusion

Euthanasia in situations in which a terminal illness is lacking, in situations of dementia and in situations in which the suffering is due to psychiatric disorders, was already possible in 2002 when the euthanasia law came into effect. The concept of an accumulation of old age complaints as such was not foreseen or discussed by the legislator, but this concept must be seen only as a specification of the criterion that there must be a medical classification. And complete life in itself has never been a basis, even today. It appears that the possibilities of the law are being used more and more. Whether this is good or bad, everyone has to decide for themselves, but it certainly does not constitute a stretch of the law.